Chapter

7 Feedback Strategies

Feedback can take several forms. It may be a "lessons learned" report that is distributed to industry, a Letter of Concern directed to a company regarding poor practices, or enforcement action such as Letters of Warning, imposing controls on the operation of foreign and domestic vessels, assessment of civil penalties or suspension or revocation of a merchant mariner's licensed or document

Vessels

In the Port State Control program, a detention is a form of feedback that is the direct result of a ship that is not in compliance with international conventions. Figure 7-1 shows the decline of detentions completed over the last 3 years. When combined with the downward trend in COTP Orders issued to foreign vessels (25 in 2000, 21 in 2001), this shows a positive trend of reduced foreign vessel movement controls by over 20% in the last year.

Figure 7-1

Foreign Vessel Actions

Year	*1999*	*2000*	*2001*
IMO Detentions	14	7	5
Letters of Deviation	N/A	37	23

Other Captain of the Port Orders were issued to vessels for reasons as varied as direction to a vessel to stay at anchorage to enable investigators to follow-up on casualty; to remain in port until a vital system component is repaired and tested satisfactorily; or to anchor in Port Angeles for a Priority 1 Port State Control Boarding.

Figure 7-2[2]

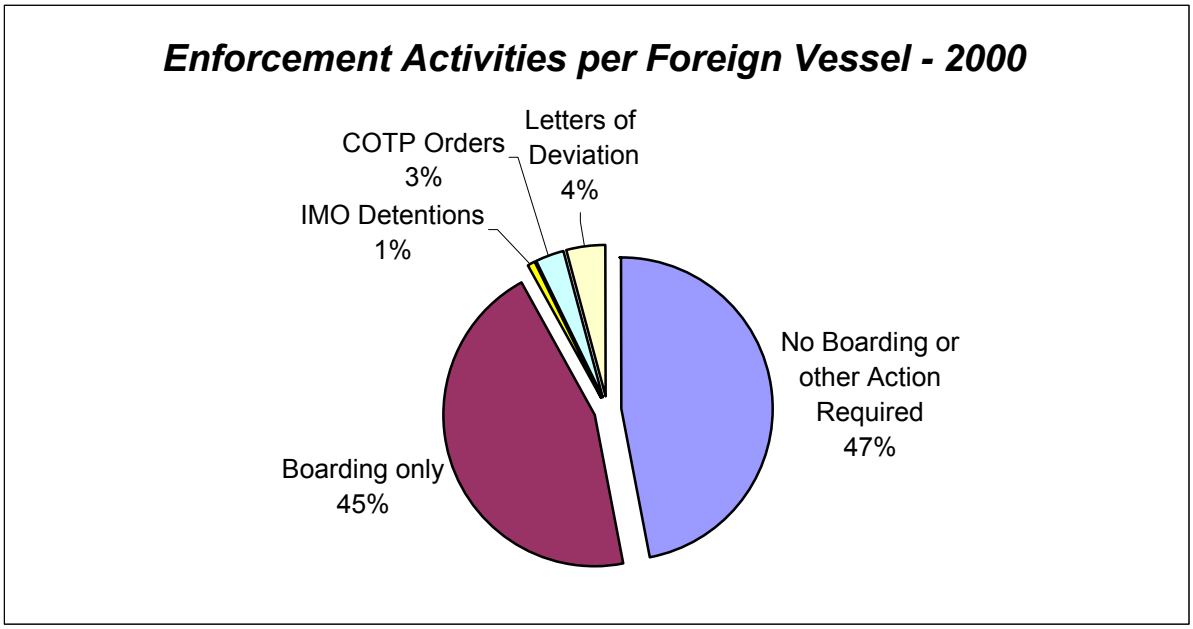
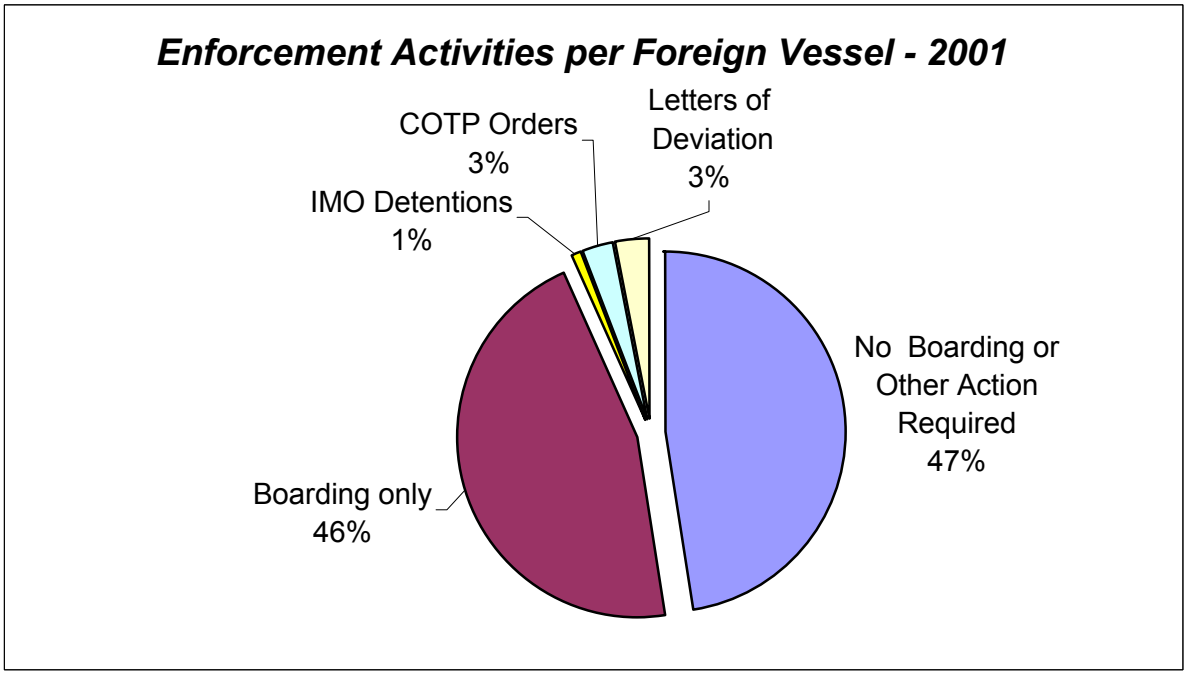


Figure 7-3



[2] A Letter of Deviation is an authorization from the Captain of the Port to temporarily deviate from the Navigation Safety Regulations in 46 CFR 164. A Captain of the Port (COTP) Order is the supervision and control of vessel movement authorized by 33 CFR 6. An International Maritime Organization (IMO) Detention is a vessel control executed under the authority of any of several international conventions including SOLAS, Load Line, and MARPOL. Boardings completed represent 100% of all targeted vessels.

Figure 7-4

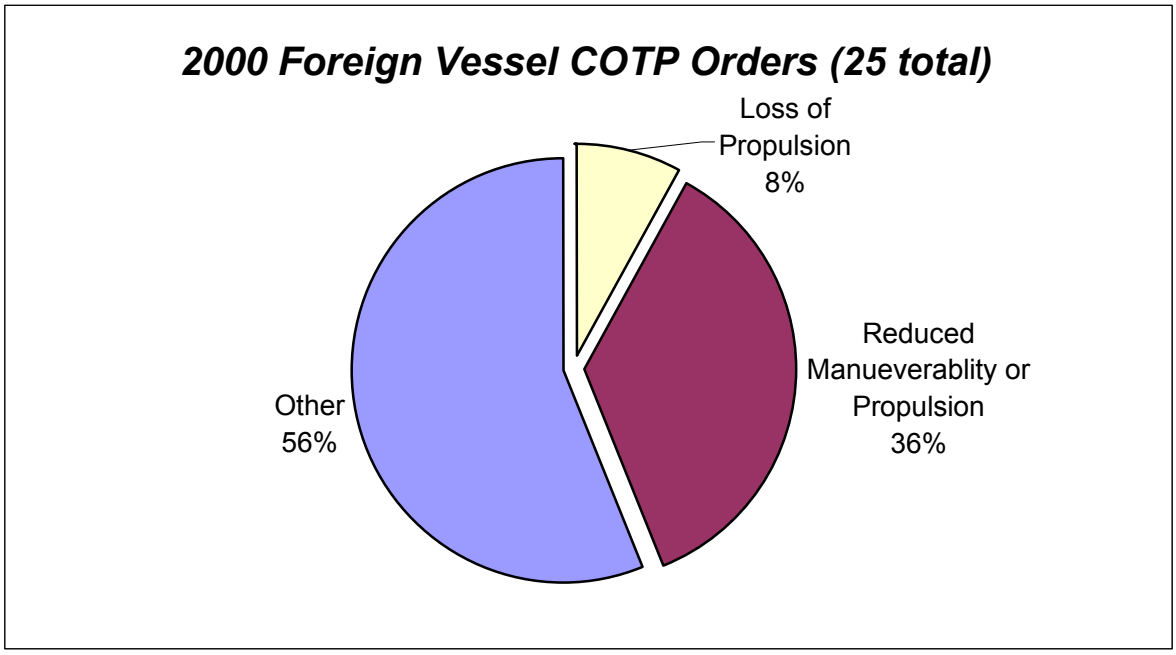
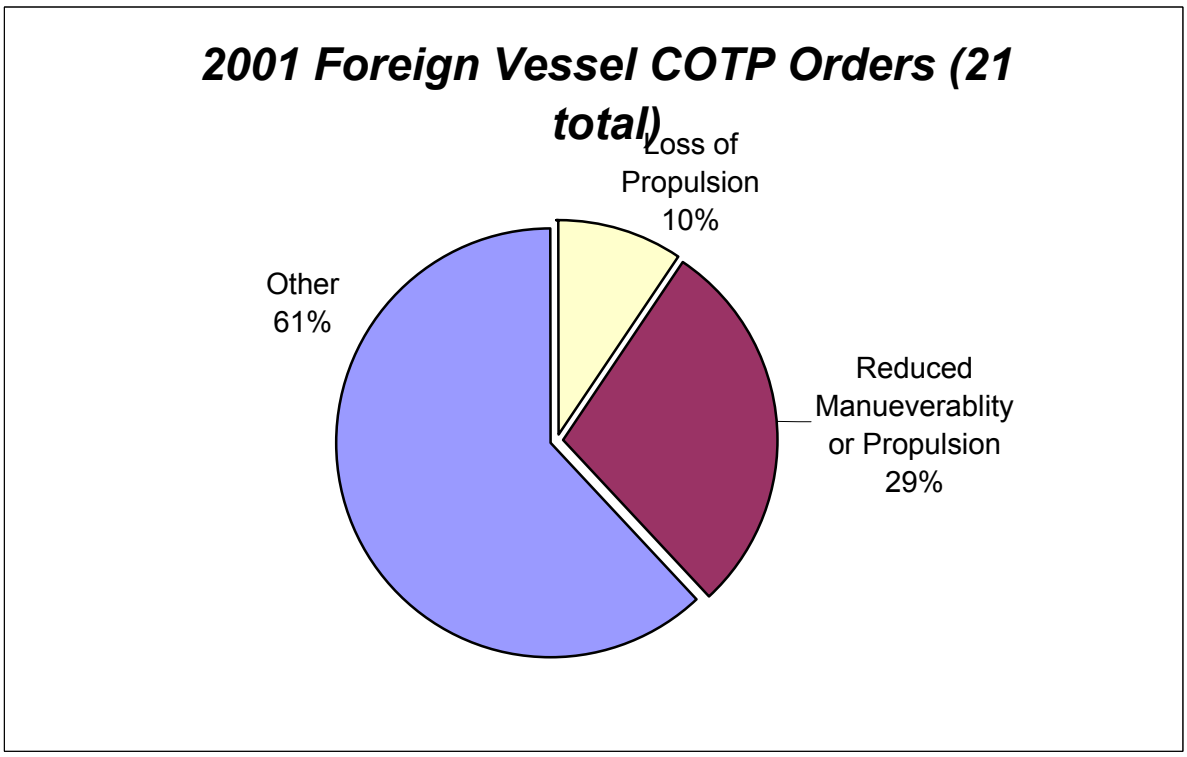


Figure 7-5



Fishing Vessels

The Fishing Vessel Safety Branch also processes the violation cases generated through Coast Guard law enforcement boardings at-sea. In the past, these cases were usually automatically submitted for

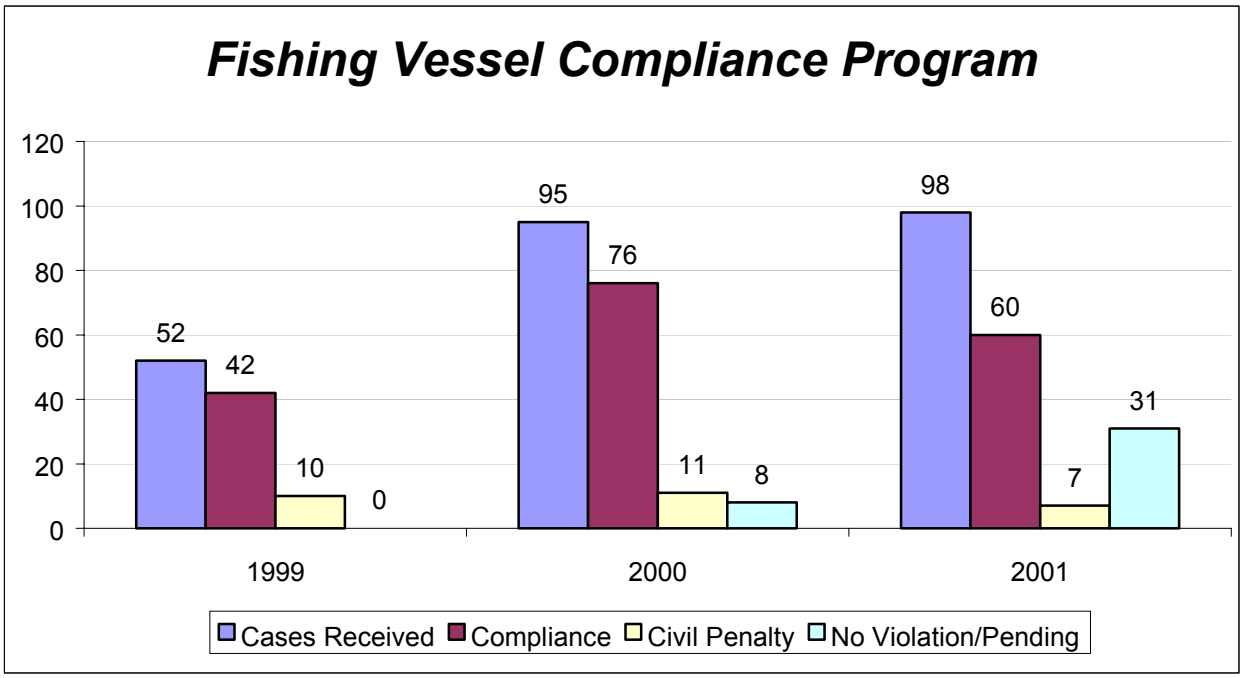
civil penalty action. This method provided neither incentive for improved compliance, nor any feedback to the initial boarding officer on the result of his/her efforts.

In May 1999 the branch launched a Compliance Program that offered operators cited for non-compliance with vessel equipment regulations an incentive to correct the violations in a timely manner. In this program, if the violations are promptly corrected, then the case is dismissed. If the operator chooses not to use the Compliance Program, then the case is forwarded to the Coast Guard Hearing Officer for final adjudication. The options available to the Hearing Officer include issuance of a Letter of Warning or assessment of a civil penalty. The failure to have achieved compliance after being cited is often grounds for assessment of stiffer civil penalty. Once the case is complete, the boarding officer and boarding unit are provided feedback on the outcome and any comments on the case.

This program has contributed to the increased participation in dockside exams. Dockside Examiners attend the vessel to ensure that the violation has been corrected. At that time, the operator is offered the opportunity to receive a voluntary Dockside Exam.

Figure 7-6 shows of the number of enforcement cases received, number of vessels correcting the violation and number of cases submitted for civil penalty:

Figure 7-6



Prior to 1999, nearly all of the enforcement cases received were sent to the Coast Guard Hearing Officer for adjudication. This program has reduced the number of cases submitted to the Hearing Officer by 88%, substantially reducing their workload.

Waterways

Lightering

Marine Safety Office Puget Sound monitors all lightering operations in zone, to prevent mishaps, and tracks them to enable analysis of the accident rate, and show the impact of the SOC on operations.

Marine Events

Monitor all marine events that affect maritime industry to identify impacts to the MTS and safety risks to the public, and consequent risk mitigation strategies required.

Tribal Fisheries

MSO Puget Sound coordinates meetings between the involved parties, monitors waterway usage conflicts related to the use of tribal fishing nets and coordinates the resolution of such conflicts.

Investigations

Personnel Investigations

The Coast Guard approach to the use of illegal drugs by mariners focuses on efforts to encourage their rehabilitation so that they may return to work. This approach is outlined in the Commandant's Decision on Appeal #2535 regarding Michael Sweeney. Of the Twenty-four drug-related cases processed in 2001, in sixteen, settlement agreements were executed. Of the other eight the mariner surrendered his credentials in lieu of a hearing 4 times and a full hearing before the Administrative Law Judge was held in the other 4. The number of mariners completing the cure process and having their credentials reinstated doubled from 2000 to 2001.

The investigators have employed a similar strategy in taking enforcement actions for misconduct, negligence, and violations of law. The largest group of non-drug related incident investigations involve negligent vessels operations (i.e. groundings/allisions) and violations of the navigation rules (Rules of the Road). In offering settlement agreements to involved mariners, the investigator identifies behaviors on the part of the mariner that resulted in the casualty or violation, and then outlines a strategy designed to address the cause. For example, in the case of a fishing vessel that collided with a barge in Puget Sound, the root cause was determined to be the loss of situational awareness by the master who had assigned himself too many tasks on an older vessel that had restricted visibility from the bridge. The settlement agreement for him included 1-month outright suspension of his license along with a requirement to attend a Coast Guard approved Bridge Resource Management Course in lieu of a second month of suspension. The master reported that his own assessment of events, as well as the BRM Course, had shown him new ways to manage his navigational tasks. In addition to settlement agreements, Letters of Concern have provided another avenue to address of risky behavior by mariners without taking official enforcement action. The letter provides a forum in which the mariner is encouraged to identify methods to improve his own operation and performance.

Figure 7-7

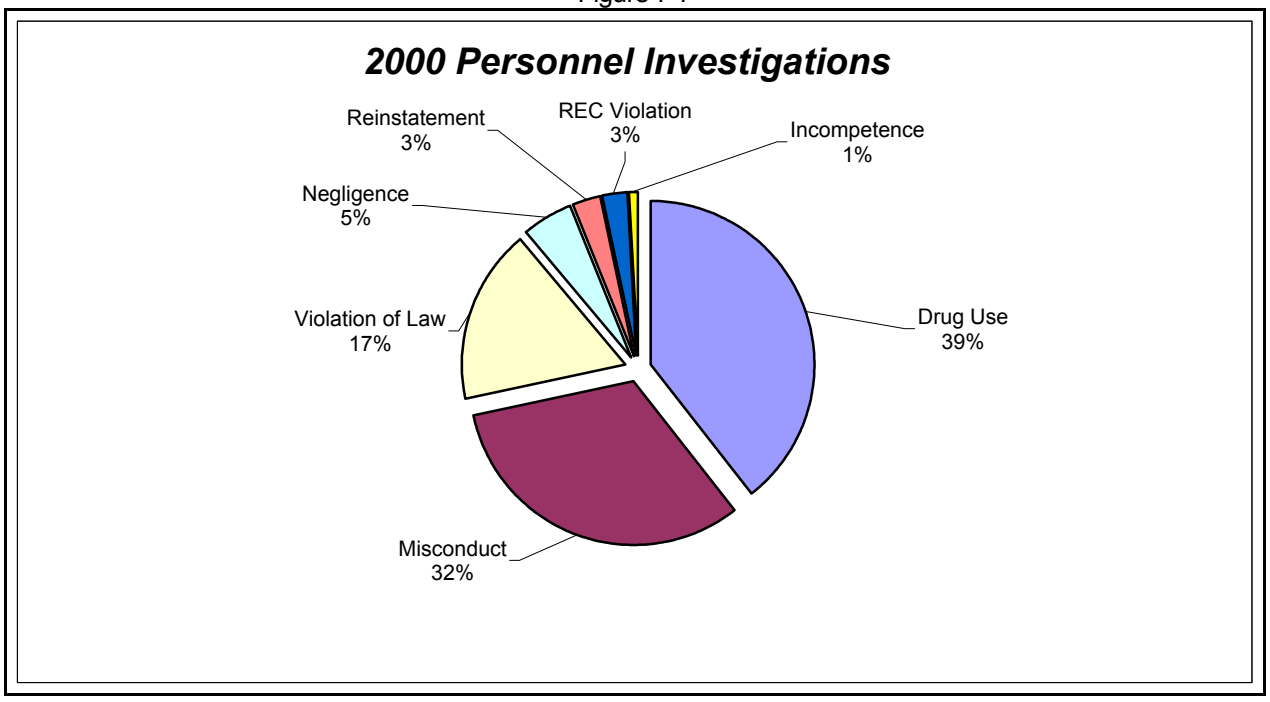


Figure 7-8

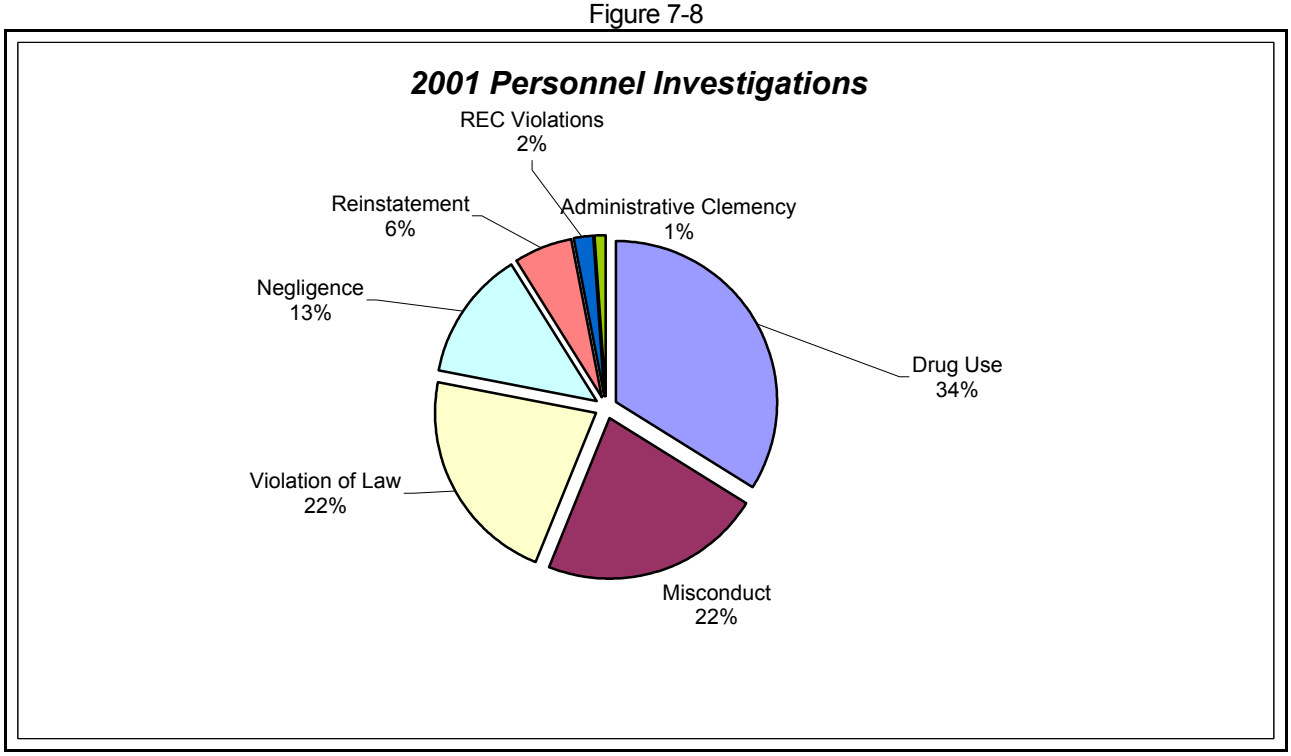


Figure 7-9

Disposition of Personnel Action Cases

Disposition	*2000*	*2001*
Closed, Lack of Evidence/No Violation	33	7
Settlement Agreements	32	16
Letters of Warning	15	13
Civil Penalty Referrals	10	6
Hearings	6	4
Wanted List Additions	4	5
Voluntary Surrenders	4	4
Verbal Admonition	4	1
Credentials Returned	3	6
Null/Void	3	2
Pending	2	20
Forwarded for other Enforcement	1	2
Letters of Concern	0	7

Marine Violation Investigations

In cases where violators are not holders of Merchant Marine Credentials, enforcement options are limited to Letters of Warning, and civil penalties. Both of these options have been used, sometimes in conjunction with a Letter of Concern, which provided an avenue for dialogue on process improvement.

High Profile Casualties

The following sampling of some results of marine casualty investigations show how the Coast Guard provides feedback to the entire system, operators, mariners and regulators. Casualty investigations may prompt recommendations to Coast Guard Headquarters for regulatory or policy changes that may help prevent casualties. The impact of the results of an investigation on risk mitigation is revealed in a review of a few high profile casualty investigations. The following abstracts of past cases provide some, but not necessarily all, of the actions that resulted from a particular casualty.

Tug Allision with Bridge

A highway bridge was hit by a tug after the Master fell asleep and missing an intended turn point. Recommendations and actions, in addition to enforcement actions against the master and the operating company, came about as a result of the investigation. Growing awareness about the critical role that fatigue plays in the casualty causal chain that had resulted in a team from the MSO and the Coast Guard Research and Development Center and the Washington State Ferries establishing a crew endurance study. As a result of a safety recommendation from this casualty, the Coast Guard teamed with American Waterway Operators members, as well as interested members of the Washington State Department of Ecology in forming a Quality Action Team to discuss crew fatigue and more importantly to identify "best practices" in the towing industry for dealing with crew fatigue, and federal work-hour limitations. The results of the QAT were forwarded to the national AWO/Coast Guard body in May of 2002.

Grounding in the San Juan Islands

Due to a lack of direction from the relief Master, an inexperienced relief helmsman steered a large passenger vessel over a charted rock. The causes of this casualty included poor communications between members of the bridge team, failure to follow company bridge watch procedures on the part of the master, lack of experience on the part of the helmsman, and the master turning his attention to matters other than the navigation of the vessel while underway. There was no skill or experience assessment made by the company in the assignment of relief crewmembers regarding their familiarity with the vessel or route. A recommendation was made that the company review their relief procedures to ensure that properly qualified persons are assigned bridge watch positions and that they are familiar with the vessel and route.

The Master was charged with negligence and settled with the Coast Guard. He agreed to one-month suspension and completion of a BRM course at his own expense. This represents an effective use of a settlement agreement to mitigate future risk potential.

Cruise Ship Casualty

While approaching the entrance to the Strait of Juan de Fuca, a cruise ship experienced a sudden turn to port with the resulting heel causing unsecured items to move, numerous personnel injuries, and damage to the vessel. Through coordination with the manufacturer of the track control system and the vessel owner/operator, it was determined that the resulting casualty was due in part to human error in the operation of the control system and in part to system design. Another similar incident occurred near Hawaii involving the same track control system. A joint effort with MSO Honolulu resulted in safety recommendations related to cruise line's Safety Management System policies/procedures and failsafe design of hardware/software that were forwarded to headquarters. The ramifications of the recommendations could influence international standards for the design and testing of track control and integrated bridge systems.

Oil Tanker Breakaways

Twice in the past few years, tankers have pulled away from their moorings during high wind and current situations at north Puget Sound refineries. Resultant safety recommendations included standardizing mooring brake settings, establishing meteorological stations at the docks to monitor conditions, and most importantly, requiring facilities to conduct an analysis of weather and hydraulic forces acting on the vessels calling at the facility and designing a mooring arrangement for each ship that is designed with those factors in mind. Additionally, the recommendation proposed that such a requirement be placed in the regulations regarding facility operations manuals.

Vessel Traffic Service Incident Reports

Incident Reports may be submitted for any event the VTS Watch Supervisor deems noteworthy. These may include collisions, groundings, allisions, law enforcement, pollution, waterway restrictions, vessel casualty, anchorage administration, near misses, VTS/Captain of the Port Intervention, search and rescue. Incident reports are used for documentation and trend analysis to see if there are improvements required to reduce risk. If the initial inquiry into the incident reveals unresolved VTS-specific operational issues, an Incident Review Board may be convened to more fully evaluate VTS policies, procedures and performance as relates to the incident. Of the 54 Incident Reports filed in 2001, one was referred to an Incident Review Board. Incidents Reports provided the impetus for such improvements as the U.S. Coast Guard/U.S. Navy Submarine Surface Operation Symposium, Operation Northern Make Way, the Recreational Boaters Guide, the Turn Point Standard of Care, and the installation of the radar at Pier 69.

VTS Puget Sound maintains a database that documents the history of violations for any specific vessel. This provides information to help the Coast Guard determine appropriate actions following a violation. Letters of Education and other forms of feedback to operators found in violation of VTS regulations have facilitated future compliance without the necessity of referring the violation for further investigation and possible enforcement action.